



Guidelines for Medical Necessity Determination for Mastectomy for Gynecomastia

These Guidelines for Medical Necessity Determination (Guidelines) identify the clinical information MassHealth needs to determine medical necessity for mastectomy for gynecomastia. These Guidelines are based on generally accepted standards of practice, review of the medical literature, and federal and state policies and laws applicable to Medicaid programs.

Providers should consult MassHealth regulations at 130 CMR 415.000 (acute inpatient hospital services), 433.000 (physician services), 410.000 (outpatient hospital services), and 450.000 (administrative and billing regulations) and Subchapter 6 of the *Physician Manual* for information about coverage, limitations, service conditions, and other prior-authorization requirements applicable to this service. Providers serving members enrolled in a MassHealth-contracted managed care organization (MCO) should refer to the MCO's medical policies for covered services.

MassHealth reviews requests for prior authorization on the basis of medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, and program restrictions.

Section I. General Information

Gynecomastia is a benign enlargement of the male breast due to ductal proliferation, stromal proliferation, or both. MassHealth considers approval for coverage of mastectomy for gynecomastia on an individual, case-by-case basis, in accordance with 130 CMR 450.204.

Section II: Clinical Guidelines

A. Clinical Coverage

MassHealth bases its determination of medical necessity for mastectomy for gynecomastia on a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the procedure, including post-operative recovery. These include, but are not limited to, the following.

1. Gynecomastia is accompanied by one or more of the following clinical signs/symptoms:
 - a. excess breast tissue that is glandular and not fatty tissue as confirmed by clinical exam or tissue pathology;
 - b. persistent pain and discomfort of the breast; and
 - c. presence of the condition for at least two years without signs of spontaneous involution, or in spite of conservative treatment.

2. A comprehensive medical history and physical exam have been conducted to identify factors contributing to gynecomastia, including:
 - a. the member's age, current height and weight, and Tanner stage of development;
 - b. the date of onset and diagnosis of gynecomastia;
 - c. documented history of clinical symptoms pertinent to the diagnosis;
 - d. previous or current use of prescribed or nonprescribed drugs contributing to a diagnosis of gynecomastia;
 - e. diagnosis of a pathological cause that is not expected to resolve spontaneously or with hormone manipulation, for example, Klinefelter's Syndrome;
 - f. current medical conditions, risk factors, and comorbid conditions; and
 - g. previous surgeries or hospitalizations.

B. Noncoverage

MassHealth does not consider mastectomy for gynecomastia to be medically necessary under certain circumstances. Examples of such circumstances include, but are not limited to the following.

1. pseudogynecomastia, which is excess adipose tissue in the male breast, but with no increase in glandular tissue; and
2. use of the procedure for cosmetic purposes.

Section III: Submitting Clinical Documentation

Requests for prior authorization for mastectomy for gynecomastia must be accompanied by clinical documentation that supports the medical necessity for this procedure.

- A. Documentation of medical necessity must include all of the following:
 1. the primary diagnosis name and ICD-9-CM codes pertinent to clinical symptoms;
 2. the secondary diagnosis name and ICD-9-CM code pertinent to co-morbid conditions;
 3. a summary of the medical history and last physical exam, including the information specified in Section II.A.2;
 4. all prior treatments used to manage the member's medical symptoms;
 5. results from diagnostic tests pertinent to the diagnosis taken within the last six months;
 6. photo documentation (front and lateral, shoulder to waist) confirming breast hypertrophy taken within the last six months;
 7. a surgical treatment plan that outlines the amount of tissue to be removed from each breast and the prognosis for improvement of clinical signs and symptoms pertinent to the diagnosis; and
 8. other pertinent clinical information that MassHealth may request.
- B. Clinical information must be submitted by the surgeon involved in the member's care. Providers must submit all information pertinent to the diagnosis using the Automated Prior Authorization System (APAS) at www.masshealth-apas.com or by completing a MassHealth Prior Authorization Request form and attaching pertinent documentation.

Select References

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These Guidelines are based on review of the medical literature and current practice in mastectomy procedures for gynecomastia. MassHealth reserves the right to review and update the contents of these Guidelines and cited references as new clinical evidence and medical technology emerge.

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Approved by: , Medical Director